MARKET INTELLIGENCE STUDY OF HEALTH INSURANCE CLAIMS IN INDIA

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INTRODUCTION

Health insurance companies covers the whole or a part of the risk of a person incurring medical expenses by estimating, the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as monthly premium or payroll tax, to provide the money to pay for health care benefits specified in insurance agreement.

Medical claims provide the ability to concentrate on a specific service line by leveraging the diagnosis or procedures codes within claims

When aggregated claims forms provide counts of patients, visits and surgeries by physicians, account for specified disease states, and provide insight across care settings

CLAIMS PROCESS AT APOLLO MUNICH HEALTH INSURANCE

The health insurance policy can be claimed through two ways: Cashless settlement at the network hospital and Reimbursement after the treatment/hospitalization, however in both scenarios an early intimation to the insurance company is mandatory. A pre-approval needs to be in place for a planned hospitalization

FOR CASHLESS SERVICE:

- At the time of hospitalization, submit the completed Pre-Authorization form at the TPA desk

- The TPA representative will then forward the form to Apollo Munich for an approval along with the concerned doctors report

- The request is then reviewed by the claim experts at the Apollo Munich and an approval is then issued, the insurance company can raise queries if required

- In case of rejection of the authorization, initiate the required treatment and claim for reimbursement later.

FOR REIMBURSEMENT OF CLAIM-

•Post hospitalization, the claim form is completed and submitted to the insurance company along with other documents like discharge summary issued by the hospital, prescriptions, bills and invoices for the medicines/treatments, etc

•In case insurance company needs any further classification/ information, it will be duly notified to the customer

• If the claim is rejected, a detailed rejection letter will be shared with the customer along with the reasons for denial, Apollo Munich takes pride in claim settlement process. Apollo claims to settle 95% of the claims within 30 days.

MARKET ASSESSMENT OF HEALTH INSURANCE CLAIMS

- Market assessment on Health Insurance Claims is a continuous process done by an organization to compare its own process with those of organizations that are leaders in the particular area.
- The purpose of assessment for claims in Apollo Munich Health Insurance is to improve efficiency, quality of service, reduce fraudulent, and improve patient satisfaction. The process involves looking at standards, best policies, their efficiency and identifying potential areas of improvement.

AIM

The aim of this study is to establish and compare the claim process of competitive organizations to improve product and service quality.

TO ANALYZE THE ONGOING CLAIM PROCESSES, DOCUMENTS REQUIRED AND THE FASTEST MODE REQUIRED TO REACH THE CUSTOMERS OF HEALTH INSURANCE COMPANIES

OBJECTIVE

The objective of the project is to deliver seamless and transparent access to healthcare through dedication, integrity and excellence in process and services, the process should be

- PAPERLESS
- HASSLEFREE
- BETTER
- FASTEST

METHODOLOGY

This study was conducted as a part of dissertation programme in APOLLO MUNICH HEALTH INSURANCE. The various methods and materials used are described under the following heads:

Study Methodology

Research Question: the following research question formed the basis of the study:

- Does Apollo Munich provide the fastest claims to the customers?
- What are the different modes of services that can be provided for claims that are fastest and hasslefree

Research Design:

A descriptive analytical study design was used for this study.

Data Collection

The study included collection of both primary and secondary data followed by a comprehensive analysis of the data.

Secondary Data: The sources for collection of secondary data included

- Online research
- Reports of the leading Market research organizations
- IRDA reports, and aggregators website
- AMHI database

Primary data: Claim assessment is done by comparing the overall claim process of competitors in the market, the survey included the modes through which the documents was submitted in respective organizations for the intimation of claims and the time taken to settle the claims.

- The survey was conducted by calling the executives of 8 respective organizations and open ended questions were asked. The organizations are Apollo Munich, Star Health Insurance, Max Bhupa, HDFC Ergo, Religare, AXA, ICICI Lombard,Bajaj Allianz
- Open ended questions reflecting the different modes involved in submitting the documents and the most approached method used by the customers to intimate the claims, as well as the total time taken for approval of claims

METHODS IN CLAIM BENCHMARKING

Claims benchmarking requires quantitative measurement of the subject on different parameters with respect to competitive organizations, the process or activity that are attempted to determine benchmarking are

- COMPETITOR ASSESMENT SHEET
- STATS OF CLAIMS AND CLAIMS PENDENCY
- CONSTRAINTS IN SETTLEMENT OF CLAIMS
- INITIATIVES TAKEN TO SETTLE CLAIMS
- INSTITUTIONAL FRAMEWORK TO REVIEW CLAIMS

COMPETITOR ASSESSMENT SHEET

Competitor assessment is a powerful tool that enables the company to assess their performance on a set of strategic priorities related to claim efficiency - and compare it with that of relevant competitors in the market, and best in class companies armed with insights gained from the tool, companies can identify performance gaps and close them with targeted change initiatives that sharpen their competitive edge.

- Business profile- performance on metrics such as number of health policies, net incurred ratios, claim settlement ratio and network of hospitals.
- FTE efficiency- in activities including business lines core operations, claims, claims distribution and marketing.
- Digital readiness- indicated by the existence of a digit offerings, use of digital platform for claims, claims documents and intimation.
- Degree of customer centricity -performance on meterics such as Net Promoter Score(NPS) and claim experience of respondents

FOR AMHI FTE EFFICIENCY IS ALL ABOUT STEPPING UP THEIR DIGITAL INTERACTIONS WITH CUSTOMERS TO SPUR TOP LINE GROWTH WHILE ENHANCING CUSTOMER SATISFACTION THROUGH FASTER AND BETTER SERVICE.

20+ BENCHMARK PROCESSES

2+ YEARS OF DATA

8 INSURANCE COMPANIES INCLUDED IN BENCH MARKING

Factors Considered For Competitor Analysis Of Claims

1. No. Of Health Policies
2. Modes of submission of claims
3. Waiting period
4. Network of Hospitals
5. Net incurred claim ratio
6. Claim settlement ratio
7. Claim experience

IMPORTANCE OF FACTORS IN COMPETITOR ANALYSIS OF CLAIMS OF HEALTH INSURANCE COMPANIES-

- Network of hospitals – Health insurance policies clearly mentions the complete list of all the network hospitals they are associated with. It is a good idea to have the network hospitals list always handy for quick reference during emergencies. This turns out to be a blessing in the event of sudden hospitalization, as the policy holder can immediately approach any of the network hospitals and capitalize upon the health insurance plan.

  More number of network hospitals will provide easy and hassle free claim intimation to the customers with better customer satisfaction.
- Number of health policies- number of health policies helps to determine the market penetration of certain policies of the respective companies.

- Waiting period- its defined as the period of time specified which must pass before some time or all of your healthcare coverage can begin. Hence this is the period during which claim is not provided.

- Modes of submission of claims- modes of submission of documents can be through, courier, physical submission of documents by the insurer or digitalized submission of documents on online portal or whatsapp.

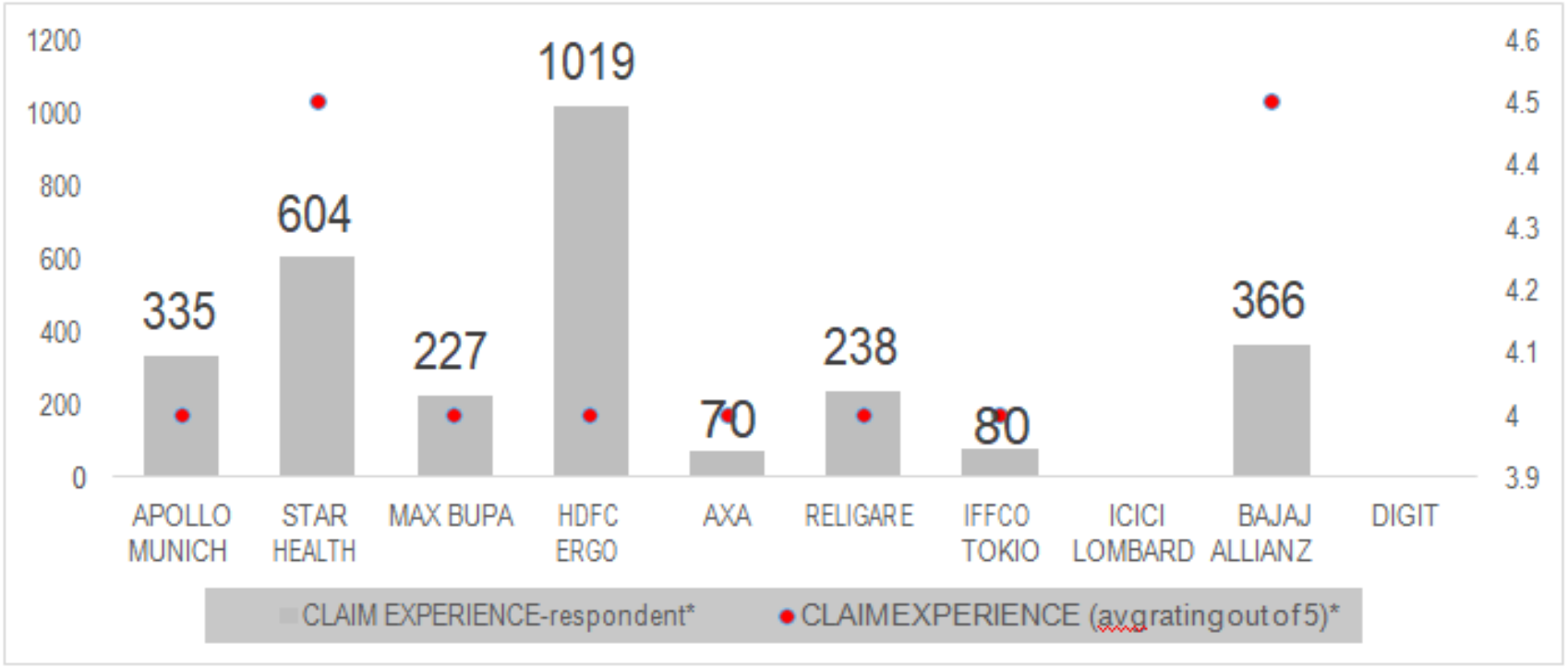
Table 1: Number of Health policies, modes of documents submission, settlement ratio, waiting period and network of hospitals of seven organizations

FACTORS	APOLLO MUNICH	STAR HEALTH	MAX BUPA	HDFC ERGO	AXA	RELIGARE	IFFCO TOKIO	ICICI LOMBARD
NO. OF HEALTH POLICIES	11	19	3	7	3	6	7	6
MODES OF SUBMISSION OF DOCUMENTS FOR CLAIMS *	HealthJinn App	mail the scanned copies	no app, watsapp	submit documents	mail the scanned copies	R care app and online intimation	submit documents	online submission
CLAIM SETTLEMENT RATIO	89%	87%	91.20%	52.58%	96.85%	51.97%	90.69%	98%
WAITING PERIOD(pre existing)	3 yrs	4 yrs	4 yrs	4 yrs	4 yrs	4 yrs	3 yrs	4 yrs
NTWK OF HOSPITALS	4500	8800+	3500+	8600+	4500+	5400+	4000+_	3600+

Source –IRDA REPORT 2018,* PRIMARY DATA OBTAINED BY CALLING EXECUTIVES OF RESPECTIVE ORGANIZATIONS

Claim experience- Claim experience depends upon the experience owned by the customers in terms of claims i.e. how fast, effective and hasslefree the claim process is. The rating is done ranging 1-5 where 1 is the least liked by the customers and 5 is most liked by the customers.

Figure 1-Number of respondents regarding experience in Claims of respective organizations and Rate of experience out of 5

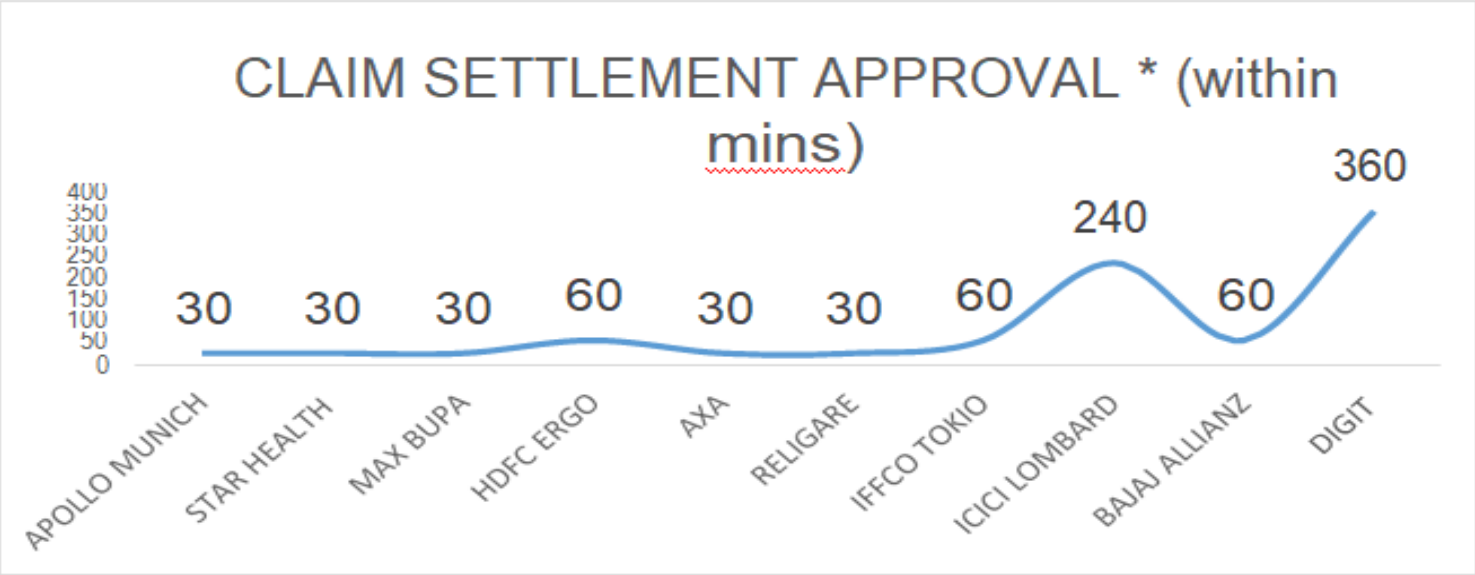


Source-BANK BAZAR REPORT 2018

Claim settlement ratio-refers to the number of times an insurer successfully processes claims from admission to payout as against the number of times it rejects them or time taken to settle the claims intimated by the customer. Higher the settlement ratio and faster the settlement time means the organization is doing a good job

A positive ratio is one where the number of claims processed successfully are higher than those rejected.

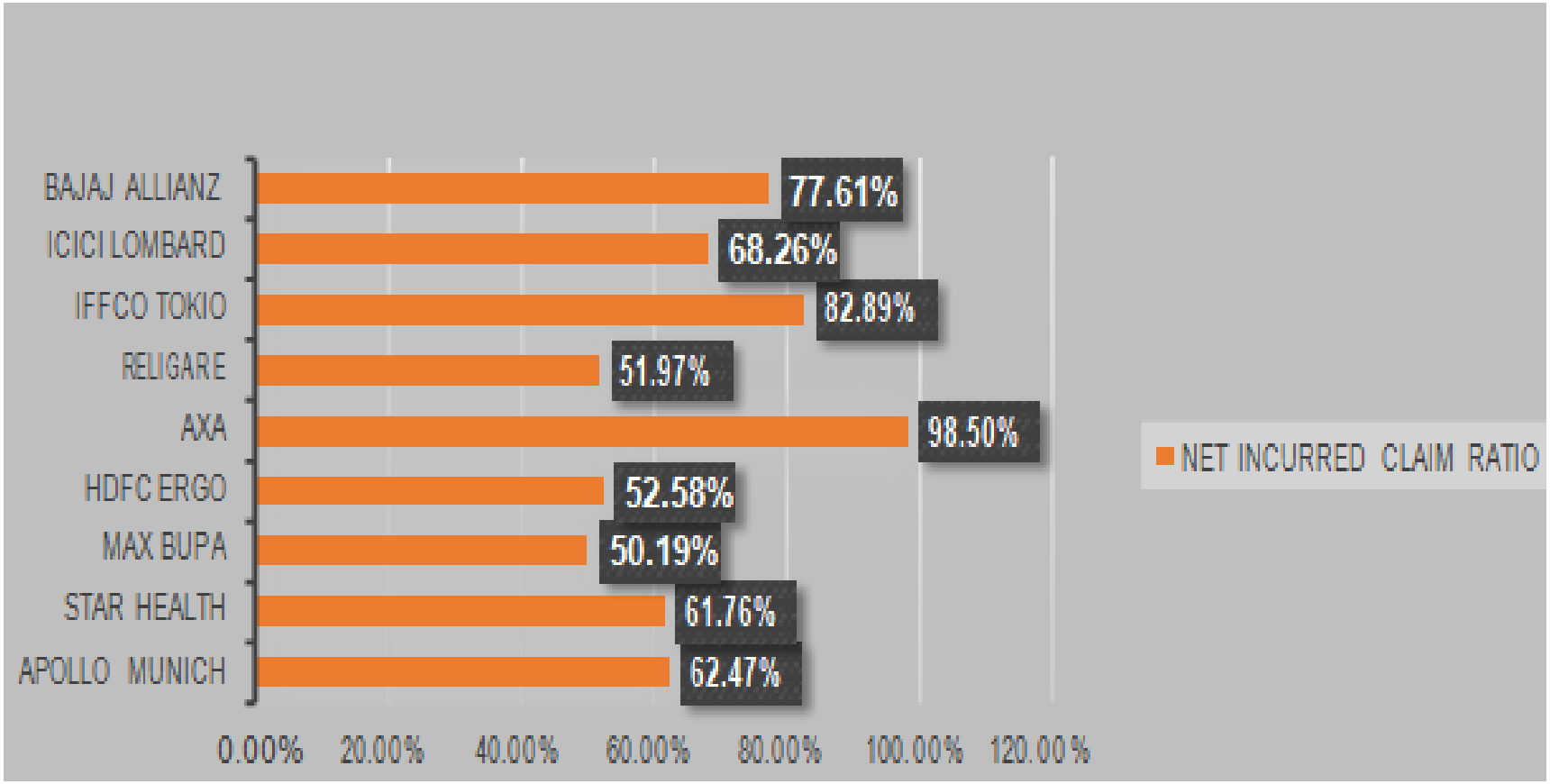
Figure 2- Claim settlement approval of respective organizations (within minutes)



Net incurred ratio-incurred claim ratio refers to the net claim paid by an insurance company as against the net premiums earned.

If the claim is less than 50% its means that the company is either hardly giving out claims or is making relatively large profit.

Figure 3- Net Incurred ratio



SOURCE-IRDA REPORT 2018

After analysis of competitor assessment sheet, consolidated report of four strong competitors were prepared

ORGANISATION NAME	INCURRED CLAIM RATIO	GRIVENCES SOLVED	NETWORK OF HOSPITALS	POLICIES ISSUED	NO OF PERSON COVERED	CLAIM SETTLEMENT RATIO	WAITING PERIOD
APOLLO MUNICH	62.47%	96.73%	4500	809364	3430000	89%	3yrs
ICICI LOMBARD	68.26%	98.91%	3600+	1014478	10585000	98%	4yrs
HDFC ERGO	52.58%	100%	8600+	654315	2383000	52.58%	4yrs
BAJAJ ALLIANZ	77.61%	99.78%	6000+	516178	11514000	83.94%	4yrs
RELIGARE	51.97%	99.30%	5400+	437555	2617000	51.97%	4yrs

The highlighted blue figure represents the desired result or benchmark of respective organizations

Source-IRDA 2018

STATS OF CLAIM AND CLAIM PENDENCY

A detailed report of claim process and claim pendency essential for bench marking was prepared, the following factors were determined in Apollo Munich, Religare, ICICI Lombard, HDFC Ergo and Bajaj Allianz

- Claims Outstanding- The number of claims which are not settled and are in pipeline

- Claims Reported- Number of claims reported in the financial year 2017-18

- Claim Settled- Number of claims settled in the 2017-18

- Claims Repudiated- Claims repudiated are the number of claims rejected due to pending documents, or some legal issues.

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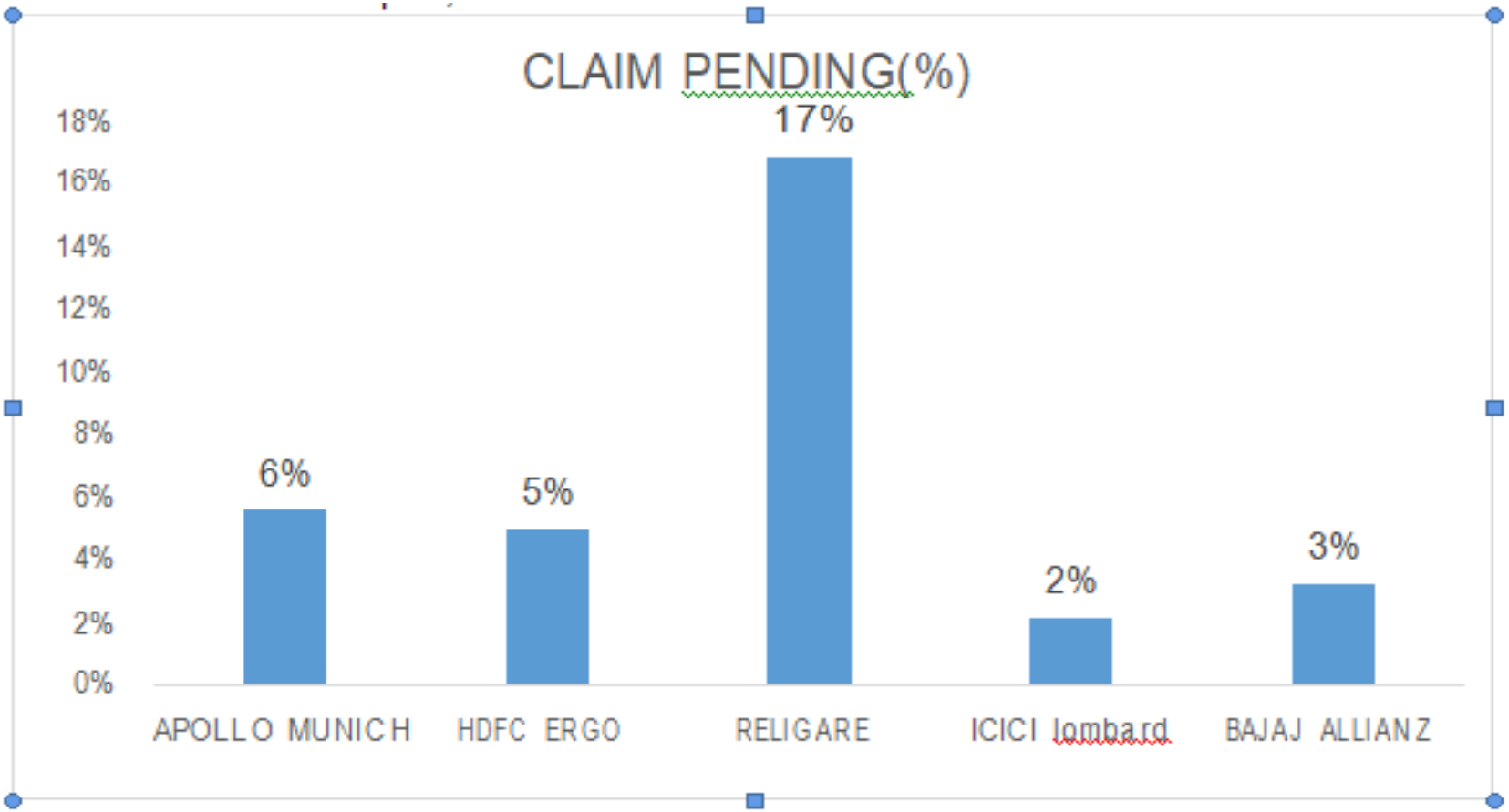
Table 3- Statistics of Claims and Claims Pendency*

FACTORS	APOLLO MUNICH	HDFC ERGO	RELIGARE	ICICI LOMBARD	BAJAJ ALLIANZ
CLAIMS O/S	8438	4221	14661	513	225
CLAIMS REPORTED DURING THE PERIOD	169,910	79434	136367	25606	4658
CLAIMS SETTLED	150,039	75956	110338	22921	4074
CLAIMS REPUDIATED	18866	3767	17724	86	660
CLAIMS PENDING	9443	3931	22966	538	149

CONSTRAINTS IN SETTLEMENT OF CLAIMS

Figure 4- Percentage of Claims pending of respective organizations



SOURCE- IRDA 2018 REPORT,* IRDA CONSUMER BOOK4

APOLLO MUNICH

CONSTRAINTS IN SETTLEMENT OF CLAIMS

•Fraud or suspected case demands verification

•Delay in completing pending documents

INITIATIVES IN SETTLING CLAIMS

•Dedicated team for reminders

•Fast track verification for timely process

INSTITUTIONAL FRAMEWORK TO REVIEW REPUDIATED CLAIMS

•Customer can request for redressal of claims rejection on communication of decision

•Rejected claims are never redressed by the initial reviewer to avoid bias

HDFC ERGO

CONSTRAINTS IN SETTLEMENT OF CLAIMS

Delay in receiving related documents

INITIATIVES IN SETTLING CLAIMS

Mail and SMS are sent to the customers

INSTITUTIONAL FRAMEWORK TO REVIEW REPUDIATED CLAIMS

•Claim repudiation authority given to senior managers

•Quarterly reports sent for review to senior management

BAJAJ ALLIANZ

CONSTRAINTS IN SETTLEMENT OF CLAIMS

Deficiencies in claim documents

INITIATIVES IN SETTLING CLAIMS

•Reminders sent to customers at 15 days interval

•Whats app facility to submit the documents

•SMS and email alerts sent to customers on each stage of the claim

INSTITUTIONAL FRAMEWORK TO REVIEW REPUDIATED CLAIMS

•Claim Review Committee with seven members

•CRC helps in review of claims

ICICI Lombard

CONSTRAINTS IN SETTLEMENT OF CLAIMS

- Incomplete details provided by insured at the time of claim intimation
- Incomplete wrong documents
- Verification of pre existing diseases

INITIATIVES IN SETTLING CLAIMS

- Frequent SMS and email sent to the customers
- In house Surveyor team present

INSTITUTIONAL FRAMEWORK TO REVIEW REPUDIATED CLAIMS

- A senior level claims team is there to review any repudiated claim represented by the insured
- Grievance redressal details available on website/ policy documents

RELIGARE

CONSTRAINTS IN SETTLEMENT OF CLAIMS

- Legal cases pending
- Pending due to investigation of fraud cases

INITIATIVES IN SETTLING CLAIMS

- Reminders sent to the customers
- Whatsapp facility provided to settle claims instantly

INSTITUTIONAL FRAMEWORK TO REVIEW REPUDIATED CLAIMS

- Redressal team for claim settlement
- Corporate training
- Broker/ agent training
- Detailed claim procedure in company website
- Proactive customer calling for claim deficiency resolution

ACCIDENT AND EMERGENCY CLAIMS

Accident and emergency claim is an additional vertical in Claims bench-marking, in which the competitors are compared on the basis of these three parameters

- Claims provided to the list of network and non-network list of hospitals
- Formalities to be fulfilled by TPA or for reimbursement claim settlement
- Hospitalization process in case of accident and emergency claim, mandatory or not

Table 4- Accident and Emergency claims*

APOLLO MUNICH	BAJAJ ALLIANZ	ICICI LOMBARD	HDFC ERGO	RELIANCE HEALTH INSURANCE
Claims provided for provided list of network Hospital	Claims provided for provided list of network hospitals	Claims provided for provided list of network hospitals	Claims provided for provider list of network hospitals	On call cashless claims provided for network and non-network list of hospitals
Reimbursement provided for non-network hospital within 15 days	Reimbursement provided for non-network hospitals. Claims intimated within 7 days after discharge	Reimbursement provided for non-network hospitals within 30 days	Reimbursement provided for non-network hospitals within 15 days	TPA has to inform the company regarding the patient status and necessary treatment
24hrs of hospitalization not mandatory.	24hrs of hospitalization is mandatory	24hrs of hospitalization is mandatory	Company did not provide any details	Hospitalization not mandatory

Note-the highlighted blue box represents the recommendations for AMHI in case of ACCIDENTS and EMERGENCY

RESULT

- After the analysis of Competitor Assessment sheet it is observed that the organization Apollo Munich Health insurance has no whats app facility for providing faster claims
- Legal cases given to external party takes more time to settle claims.
- More time is taken by Fraud and abusive management team to settle the claims

CONCLUSIONS

Insurers have a unique opportunity to leverage multiple data sources to create deeper, customer relationship and to become more efficient. If we help our clients in this effort the sector will be well positioned to play a prime role in emerging ecosystems.

Future of Insurance will be determined by the net effort of multiple enablers like

- Digit adoption- to enhance access to data and raise process efficiency through RPA/ AI
- Big data Analysis- to make sense of the vast amount of data generated and consequently create value.

RECOMMENDATIONS

Some recommendations that are made to AMHI after analyzing the results of the study are as follows

- Cashless claim facility can be provided to the provider of non-network list of hospitals in case of Accidents and Emergency
- In house team of claims surveyor can be incorporated for expeditious survey of claims, system triggered SMS to insured at various stages of the claims like survey or assignment with surveyor details, post survey completion post payment etc. can be provided to the customers
- Technology being a core strength, AMHI can built Whatsapp facility to submit documents for settlement of claims, which will reduce the average five days TAT

CASHLESS PROCESS FOR ACCIDENT AND EMERGENCY

1

Person Met With Accident Or Emergency

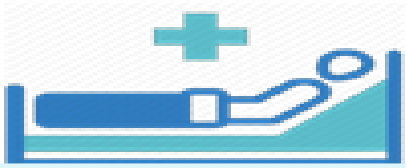
2

Taken To Nearby Hospital

3

TPA Desk Calls AMHI

4



Details given to AMHI of the accident and treatment given to the patient by TPA

5

Cashless Facility Provided

The prime responsibility of any Health Insurance company is to honor a valid claim in the need of the hour. By embracing Mobile instant messaging platform like Whatsapp we can provide a prompt and afresh service option to enhance comfort and benefits to the customers

CLAIMS SUBMISSION BY WHATSAPP

1

Customer has to message company on its number available on Whatsapp

2

Dediacted team accessing number, sends an immediate response to the customer

3

Customer has to upload claim document on a link which the claim team will be sharing with him/her

4

AMHI will communicate its decision to the customer on his/her number

5

Credit claims benefits to his/ her bank account if any

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Thank you